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AUDITOR GENERAL

OF CALIFORNIA

AUDIT OF THE MEDI-CAL CLAIMS PROCESSING SYSTEM

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AUDIT OF THE MEDI-CAL CLAIMS PROCESSING SYSTEM

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Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents a report prepared under contract by the Compass Consulting Group concerning the adequacy of the Medi-Cal Claims Processing System to prevent erroneous payments.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

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SUMMARY

Medi-Cal is a $4 billion program which is funded jointly by the State and the Federal government. The program is authorized by Title XIX of the Social Security Act and Section 14000 et seq. of the Welfare and Institutions Code to provide health services to the State's poor and needy. Since 1966, the State has contracted with a fiscal intermediary to process medical service claims rendered to Medi-Cal recipients. The Department of Health Services has contracted with Computer Sciences Corporation (CSC) since 1978 to provide Medi-Cal fiscal intermediary services. The contract is managed and monitored by the Fiscal Intermediary Management Division (FIMD) within the Department of Health Services (DHS). The claims are processed with the aid of the Medicaid Management Information System (MMIS), a large-scale claims processing and reporting computer system.

During FY 84-85, CSC paid some 48 million claims totaling approximately $3.7 billion. Based upon our preliminary review of the prior work of others, interviews with State and fiscal intermediary staff, and a review of documents and reports relevant to Medi-Cal claims processing, we found no evidence of a high claims processing error rate. The most comprehensive prior study included in our review estimated a maximum overpayment of less than one-tenth of one percent of total paid claims for the period reviewed.

During this preliminary review, however, we identified a discrete number of areas for which some payments may have been made to medical service providers in excess of amounts allowed under Medi-Cal policy. In order to verify and determine the magnitude of these potential problem areas, six issues were selected for more detailed testing. Our review was designed to focus on the prepayment processing aspect of each of these issues.

DHS has recently contracted with hospitals to provide inpatient services to Medi-Cal recipients under a prospective per diem rate. We reviewed three aspects of claims processing for these hospitals. We found that, in some cases, separate payments were being made for outpatient services which should have been included in the per diem rate. We estimate that, in our four sample months, a potential $70,000 in such payments were made. It should be noted that DHS has not instructed CSC to implement prepayment edits for these billings but rather has elected to pursue these payments in a postpayment recoupment process. We also found that, although hospitals were not always correctly billing additional common day inpatient services, no overpayments resulted and that DHS has instructed CSC to implement prepayment edits to correct the problem. We further found that hospitals were billing for contract and non-contract fee-for-service outpatient services correctly.

We found that overpayments were made to physicians and/or facilities when the same radiology and pathology services were billed by both. We estimate that some $1.3 million was paid to providers who billed incorrectly. DHS has now instructed CSC to implement certain prepayment edits to eliminate these payments. DHS has also started to recoup previous overpayments through a postpayment review process.

Physicians may bill Medi-Cal one global fee for obstetrical care, or they may bill separately for each obstetrical service provided. The number of global fees for one recipient may not exceed a frequency of one fee per eight months. Our review indicated that existing prepayment edits were effectively preventing overpayments. However, we did note that, for some claims, the error code wording or logic may cause confusion on the part of claims examiners, resulting in a potential for improper error overrides.

Physicians may bill for services either individually or through group practices. We reviewed a sample of claims to determine if physicians could bill both ways for the same service. Although overpayments in these cases could occur, we did not find that such overpayments were being made.

DHS and psychiatric practitioners have developed guidelines on the frequency and duration of services provided to Medi-Cal recipients domiciled in institutions. We found, however, examples of billings which exceeded

these service guidelines. We estimate that at least 7,860 claims, totaling an estimated $212,506 were paid in excess of these guidelines. Medi-Cal policy does not, however, mandate enforcement of these guidelines on a prepayment basis.

During our preliminary review, there were indications that anesthesia service claims were being paid in excess of reasonable service levels. With the exception of one case, our review did not support this conclusion. There is no specific service limitation on anesthesia services because of the medical complexity of such services. Our review did not indicate a pattern of billing in excess of reasonable levels. We also reviewed the use of modifiers in anesthesia billing. We found some instances where physicians misused certain anesthesia modifiers, but the system correctly reduced the extra units of service. We did, however, find some providers who incorrectly billed other anesthesia modifiers, resulting in payments in excess of policy limits. We estimate that incorrect use of modifiers for anesthesia injections resulted in an estimated $15,000 in overpayments.

CHAPTER I

INTRODUCTION

BACKGROUND

In July 1965, the Congress passed Title XIX of the Social Security Act, establishing Medicaid. In March 1966, the California Legislature authorized the State's participation in the Federal Medicaid program. This authorization is codified in Section 14000 et. seq of the Welfare and Institutions Code. The California Medical Assistance Program (Medi-Cal) is funded jointly by the Federal and State government and provides a wide range of health care benefits to needy Californians. The Department of Health Services (DHS) is designated by statute as the single State agency responsible for the administration of the Medi-Cal program and for the coordination of other Federal, State, and local agencies involved with the program.

Since the inception of the program, the State of California has contracted with a fiscal intermediary to perform claims processing and related services. The (then) Department of Health Care Services first contracted with the California Blue Shield and Blue Cross Plans for fiscal intermediary services. In 1972, the Blue Shield and Blue Cross Plans created Medi-Cal Intermediary Operations (MIO), which assumed the fiscal intermediary responsibilities of the Plans. In August 1978, the Department of

Health Services awarded Computer Sciences Corporation (CSC) its first contract for processing Medi-Cal claims. This contract required CSC to design, develop, implement, and operate the California Medicaid Management Information System. In 1983, the Department of Health Services issued a new RFP for Medi-Cal fiscal intermediary services. This procurement again resulted in a contract award to CSC; claims processing under the new contract requirements began in July 1984. The Fiscal Intermediary Management Division (FIMD) within DHS is responsible for managing the fiscal intermediary contract.

MEDICAID MANAGEMENT INFORMATION SYSTEM

Overview

The Medicaid Management Information System (MMIS) is the system design for a computerized claims processing and information retrieval system. The California MMIS consists of six major subsystems: Provider, Recipient, Reference, Claims Processing, Management and Administrative Reporting, and Surveillance and Utilization Review. Briefly, the functions of each of these subsystems are as follows:

- Provider Subsystem - This subsystem maintains a file of eligible providers and provider data used for claims processing, administrative reporting, and surveillance and utilization review.

- Recipient Subsystem - This subsystem maintains information regarding Medi-Cal recipients for use in claims processing, surveillance and utilization review, and management reporting.

- Reference Subsystem - This subsystem maintains files of procedures, diagnoses, drug formulary listings, and reimbursement information to be used in processing claims.

- Claims Processing Subsystem - This subsystem processes claims to determine allowable Medi-Cal payments to enrolled providers for covered services to eligible recipients.

- Management and Administrative Reporting Subsystem (MARS) - This subsystem provides information and statistics to assist management with fiscal planning, control and monitoring, and program and policy development.

- Surveillance and Utilization Review Subsystem (SURS) - This subsystem provides information and statistics to assist

management in developing profiles of health care delivery and utilization patterns of providers and recipients and to reveal potential misutilization and possible defects in quality of service provided under the Medi-Cal program.

Description of Claims Processing

The claims processing component is the focal point of the MMIS, because it interfaces with all of the other subsystems. It is in this subsystem that provider bills are received and prepared for payment or denial. Claims processing involves a combination of manual and automated functions performed by CSC. These functions are as follows:

- Claims Receipt, Preparation, and Microfilming - Claims are received in CSC's mailroom, sorted and screened, batched, microfilmed, stamped with a claim control number (CCN), and distributed to various stations for further processing.

- Data Entry - Data is entered via Optical Character Recognition (OCR), manual key data entry, or magnetic tape.

- System Processing - All entered claims are passed through data validation edits, provider-related edits, recipient-related edits,

pricing edits, and procedural relation edits. Claims which fail edits are suspended, denied, or returned to the provider for claim resubmission.

Claims that successfully pass the daily edit cycle are run through a weekly audit cycle to further validate the claim. Claims which pass that cycle are processed for checkwriting. Those claims which fail the audit cycle are suspended for manual review, denied, or routed for medical review.

- Suspense Processing - Suspense processing involves error correction, manual pricing, and medical review.

- Payment Processing - Claims approved for payment are transmitted on a payment tape to the State Controller's Office (SCO). The SCO mails the checks to providers.

System Maintenance Requirements

The Department of Health Services is responsible for the development of Medi-Cal policy consistent with California law and with Federal Title XIX laws and regulations. When changes to the MMIS are required to implement policy, those changes are communicated to Computer

Science Corporation for implementation. The implementation is monitored by the Fiscal Intermediary Management Division.

The changes are communicated to CSC through several instruments. These instruments are the contract between CSC and DHS, Operating Instruction Letters (OILs), System Development Notices (SDNs), and Change Orders (COs).

CSC is responsible for ensuring that the MMIS is in compliance with the requirements imposed by these documents. All changes to the MMIS are required by the contract to be authorized by DHS.

OBJECTIVES OF THE AUDIT

The objectives of the audit that was performed by Compass Consulting Group under contract to the Office of the Auditor General were to:

- Evaluate CSC's operation of the California Medicaid Management Information system and to recommend appropriate changes.

- Identify potential payment problems in at least ten areas which warrant further review.

- Select six of these potential problems and conduct a detailed evaluation of the extent of, causes of, and cost to the State of each of the potential problems.

EVALUATION OF CSC PERFORMANCE

Our evaluation of CSC performance consisted of a general assessment of CSC's operation of the MMIS and a review to identify potential problem areas.

Our general assessment of CSC operations relied heavily on the prior work of others, including reviews by the Department of Health Services, previous Auditor General audits, audits by the State Controller's Office, and reviews by the Federal Government. We found that, although the system paid some 48.6 million claims per year totaling approximately $3.7 billion in provider payments, the number of erroneous payments was relatively very small.

In the most comprehensive study reviewed, which was conducted under the auspices of FIMD, it was found that the claims processing error rate resulted in a maximum overpayment of less than one-tenth of one percent of total claims paid for the period. This study consisted of a large stratified sample of paid claims. The dollar impact of this error rate at the

95 percent confidence level was an overpayment of $998,383, with a sampling error of ± $823,210 in a universe of approximately $2 billion.

We did, however, identify a number of areas in which prepayment edits did not exist, resulting in a potential for overpayments to Medi-Cal providers. Further review indicated that each of these areas was an issue in which DHS had not instructed CSC to implement such prepayment edits. We also found a small number of claims which had been mispaid by CSC, resulting in overpayments. These issues are described in detail in the next section.

IDENTIFICATION OF POTENTIAL PROBLEM AREAS

The identification of potential problem areas resulted from a series of interviews and a review of a variety of documents. Of all issues analyzed, six were selected which appeared to have potential for overpayment to providers.

Interviews were conducted with FIMD management and staff. The managers and staff of other DHS divisions were also interviewed, including Audits and Investigations, Medi-Cal Operations, and Administration. Managers and staff of the State Controller's Office were also interviewed.

Documents from a variety of sources were reviewed, including prior Auditor General reports and reports by the State Controller's Office. System Performance Review results and State Medicaid Operations Reports prepared by the Federal Health Care Financing Administration were also reviewed. Further, internal DHS reports were reviewed, including FIMD Problem Statements and various Departmental correspondence related to Medi-Cal claims processing.

Based on the results of the documentation reviews and the interviews, six areas were selected for in-depth audit tests. These issues appeared to have the most potential for resulting in payments in excess of amounts authorized under Medi-Cal policy. The six areas were:

- Contract hospital billing
- Radiology/pathology split billing
- Global versus separate obstetrical (OB) care
- Group versus rendering provider billing
- Psychiatric service billing
- Anesthesia service limits

The contract hospital billing area was then subdivided into three specific issues: included services, fee-for-service billing, and common day billing. Similarly, while reviewing anesthesia service limits, we evaluated the use of anesthesia modifiers.

SCOPE AND METHODOLOGY

Sampling Frame

For each of the six audit areas, we selected claims from four sample months of the Monthly Remittance Activity File (RF-F-034). To ensure that selected claims were distributed throughout the fiscal year, months were randomly selected from each of the fiscal quarters. The RF-F-034 file was selected as our sampling frame, since all paid and denied claims lines are included in that file.

Claims Selection Criteria

For each of the following tests, claims were selected for the four sample months. A random selection computer program was used to select claims from the file:

- Contract hospital OB common day billing - For a sample of contract hospitals, claims with OB care procedures and accommodation codes were selected.

- Contract hospital admissions with outpatient services - For a sample of contract hospitals, inpatient claims were selected.

- Contract hospital services billed separately - A sample of claims for contract hospital and fee-for-service provider ID numbers for certain ranges of procedure codes were selected.

- Group versus rendering provider billing - Medical claims billed by group providers were selected.

- Global versus separate OB care - Medical claims with global OB care procedures were selected.

- Radiology/pathology split billing - Outpatient radiology/ pathology claims were selected.

- Psychiatric service billing - Medical claims for individual physicians for institutional psychiatric services were selected.

- Excessive anesthesia services - All anesthesia claims were reviewed from a sample of provider profiles. The claims sample was not generated from the RF-F-034.

- Anesthesia with difficult positioning modifier - Medical claims with a difficult positioning modifier (32) and specific procedure codes for which difficult positioning is not appropriate were selected.

- Anesthesia services with modifiers - Specific procedures codes for which anesthesia modifiers are not allowed were selected.

A more detailed discussion of the claims selection criteria is presented in Appendix A.

Claims Detail Report (CDR) Review

Claims Detail Reports (CDRs) provide claim profile information pertaining to a single recipient or provider. Claims payment history on the recipient or provider was obtained for 18 months (January 1, 1984 - June 30, 1985).

As indicated in the preceding section, our sample was a selection of claims. A claim is defined as a single service provided by a single provider

for one recipient on a defined date of service. Because most of our audit tests were of the sample claims in relation to all claims in history for that recipient or provider, it was necessary to review a claims profile of the recipient or provider. The CDRs provided that profile.

For each of these tests, claims were selected for CDR review. Briefly, the evaluation methodology for each test was as follows:

- Contract hospital OB common day billing - 339 CDRs were reviewed to determine if Accommodation Code 3998 (common day code - mother and baby) and separate OB Accommodation Codes 3160 and 3170 were billed for the same date of service.

- Contract hospital services billed separately - Evaluation of this issue did not require CDR review because the selected claims were billed either under the contract provider ID or under the non-contract provider ID. A profile was not required.

- Contract hospital admissions with outpatient services - 380 CDRs were reviewed to determine if contract hospitals were billing separately for outpatient services for recipients with inpatient stays.

- Group versus rendering provider billing - 384 CDRs were reviewed to determine if the same rendering provider billed under different provider numbers for the same service.

- Global versus separate OB care - 358 CDRs were reviewed to determine if both global and separate OB care procedures were billed and paid for a single pregnancy.

- Radiology/pathology split billing - 374 CDRs were reviewed to determine if both a facility and physician billed and were paid for the same radiology or pathology procedure.

- Psychiatric service billing - 383 CDRs were reviewed to determine if providers billed and were paid for psychiatric services in excess of limitations.

- Excessive anesthesia billing - Evaluation of this issue was based on a review of 343 CDRs.

- Anesthesia with difficult positioning modifier - Evaluation of this issue did not require CDR review because the review could be made on the basis of the selected claim.

- Anesthesia services with modifiers - Evaluation of this issue did not require CDR review because the review could be made on the basis of the selected claim.

Further Review

After identifying the claims and related history for each of the audit tests, further review was required of how each claim was processed (e.g., whether the claim was manually reviewed or suspended for medical review, or the error overridden, etc.). The MMIS report, Paid Full Status, MR-O-154, provided detailed information on how each claim was processed by the system. Copies of claim documents and copies of relevant MR-O-154 pages were obtained for each claim to support the analysis.

CHAPTER II

CONTRACT HOSPITAL BILLING

OVERVIEW

In an effort to contain the costs of the Medi-Cal program, changes in California law were made to allow the reimbursement of acute care inpatient services under a contracted, prospective per diem rate. We reviewed three aspects of this hospital contracting and billing process. We found instances in which contract hospitals had received reimbursement for amounts in excess of contract provisions. However, DHS officials indicated that postpayment activities should ensure recoupment of any overpayments.

BACKGROUND

Under the provisions of Assembly Bill 799 and Senate Bill 2012, the State may enter into contracts with selected hospitals for provision of all acute care inpatient services and certain outpatient/physician services to Medi-Cal beneficiaries under a prospective per diem rate. Of the approximately 600 hospitals in California, DHS has entered into contracts with about 274 hospitals. These contract hospitals, along with ten hospitals under the Los Angeles County Waiver program, are the only hospitals

authorized to provide services to Medi-Cal beneficiaries, except in life-threatening or other emergency situations.

Prospective rate contracting is a complex process involving the issues of hospital operating costs, medical equipment acquisition, medical education, and Medi-Cal utilization. Similarly, the processing of claims (bills) submitted by these hospitals must reflect these complex issues.

We reviewed the prepayment claims processing issues related to three aspects of hospital contracting. These aspects were selected because of the potential for reimbursement of these hospitals in amounts in excess of that allowed under the terms of the contracts. The aspects reviewed were:

- Separate billing for outpatient/physician services which should be included in an inpatient billing (Included Services Billing)

- Fee-for-service billing of certain services which should be included in the contract per diem rate (Fee-for-Service Billing)

- Billing separately for mother and newborn child when both are obstetrical inpatients in the same hospital on the same day (Common Day Billing)

INCLUDED SERVICES BILLING

Certain outpatient/physician services have been included in the per diem rate of hospitals by contract. These services were separately negotiated for each hospital and, thus, could vary from one contract hospital to another. These included services must not be billed separately during an acute inpatient stay. Further, if included services were provided by the hospital's outpatient department prior to the admission of a beneficiary to an inpatient stay but within 24 hours of that admission and the services are related to the reason for admission, the services must be billed on the inpatient claim form and be reimbursed under the contract per diem rate.

Billing Patterns

We reviewed 367 inpatient stays of a random selection of contract hospitals. We determined that 49 outpatient billings, totaling $709.85, were reimbursed for services related to 20 of these inpatient stays.

Based on our review, we estimate at the 95 percent confidence level that contract hospitals are separately billing, and being reimbursed for, included outpatient services for between 3.13 percent and 7.77 percent of the inpatient stays at those hospitals.

There is a 97.5 percent probability that at least 3.13 percent of the 21,988 contract hospital inpatient stays in the four-month period, or 688 stays, involved separately billed and reimbursed outpatient services which should have been included in an inpatient billing. We estimate that separate billings totaled at least $14,732 in reimbursements in excess of that allowed under the contracts.

Given our sampling precision, there is a 97.5 percent probability that as much as 7.77 percent of inpatient stays during the four-month period had separately billed outpatient services totaling not more than $70,142. Because we could not determine the total number of inpatient stays at contract hospitals for the 1984-85 fiscal year, we could not project the results of this finding to the entire year.

Prepayment Edits

The claims processing system does not have prepayment edits which prevent reimbursement for included services billed separately within 24 hours of admission. DHS officials have stated that a policy decision was made to pursue recoupment of such reimbursements on a postpayment basis.

The system does have an edit (edit 267) to prevent reimbursement of an included service if billed on an outpatient form but for which the indicated

place of service is inpatient hospital. Thus, the system effectively prevents reimbursement of included, but separately billed, services during the inpatient stay, provided that the hospital identifies the place of service correctly.

We analyzed how a prepayment edit would be constructed to prevent separate payments for included services within 24 hours of a related admission. The following is a brief description of the logic required:

- When an outpatient claim is received, it should be compared to recipient history to determine if there is an inpatient admission; if none, pay the outpatient claim because the service was covered by the Medi-Cal program. When the inpatient claim is received, edit the claim against recipient history and deduct the amount of included outpatient services paid from the authorized payment on the inpatient claim.

- When an inpatient claim is received from an contract hospital, it should be compared to recipient history (as in the previously described process) to determine if there were any prior included outpatient services. When subsequent outpatient claims are received, they should be edited against recipient history; if an inpatient admission was within 24 hours of the outpatient claim, the claim should be suspended for review of related services.

- When the inpatient claim and outpatient claim(s) are received in the same cycle, the claims in the cycle should be included with recipient history in the review.

In addition to the edit rules described above, decisions must be made as to what constitutes a 24-hour period. The inpatient claim has the hour of admission, but the outpatient claim does not have the hour of the service. Further, before an outpatient claim for included services is denied, the diagnosis codes on the outpatient claim and the inpatient claim must be compared so that only included outpatient services related to the reason for admission should be denied.

Conclusion and Recommendation

From our review, we found that payments are being made to contract hospitals in amounts in excess of those allowed under the contracts and Medi-Cal policy. However, a prepayment edit to prevent reimbursement for included outpatient services within 24 hours of a related admission would be extremely complex and, therefore, costly to develop. Furthermore, the payments in excess of policy are not sizable enough, based on our review, to justify the expense of a prepayment edit. Accordingly, an appropriate alternative is for DHS to identify and recoup these excess reimbursements through the postpayment review process.

DHS officials stated that such a postpayment review process is currently in effect. These officials pointed out that postpayment review staff receive a report (CP-O-200) on outpatient services within 24 hours of an admission. We did not review the Department's postpayment review process to evaluate the efficacy of the identification and recoupment of such payments.

We recommend continuation of the recoupment of excess reimbursements through the postpayment review process with periodic review by DHS of the results of the recoupment effort.

FEE-FOR-SERVICE BILLING

When the hospital contracts were established, the contract hospitals were prohibited from billing certain services separately. These services were deemed to be included in the prospective per diem rate.

The contract hospitals are assigned new provider identification numbers through which contract services are to be billed. Non-contract services, which could be reimbursed separately, are to be billed under the previous provider identification number for that provider.

We reviewed a sample of claims to determine if the contract hospitals were billing contract services separately under non-contract

provider IDs. Specifically, we reviewed five different procedure code ranges included in our sample of 50 hospital contracts to determine if non-contract provider ID numbers were billed for these services.

From our review of the sample, we found that the contract hospitals were not billing the selected procedure code ranges under a fee-for-service ID number but appropriately under their contract ID numbers. Any claims that were paid to a contract hospital on a fee-for-service basis were paid for dates of services prior to the effective date of the hospital contract. Hence, sampled claims were paid correctly.

COMMON DAY BILLING

Most contract hospitals may only bill for one accommodation (room and board) charge per day to include both the mother and child when both are post-delivery inpatients of the hospital. This charge is referred to as a common day billing. However, some hospital contracts allow billing of common day and per diem accommodation days for the same period of stay for the mother and/or child under neonatal or other acute/intensive care circumstances.

In order to enforce these different billing policies, the system includes an edit designed to verify that common day and per diem obstetrical

(OB) or nursery accommodation charges are only billed within the same period of stay by hospitals that have negotiated exceptions to common day billing. The system is also designed to edit for OB (code 3160) and nursery (code 3170) and common day (code 3998) accommodation codes billed on separate forms for the same dates of service which may result in multiple billings for the same service. In addition, the Department requires that all contract hospitals billing for OB care use specified accommodation codes.

Based on our review of this issue involving a sample of 339 OB claims submitted by contract hospitals, no billings for both mother and child were found when a common day billing was required. Although we found OB accommodation codes billed in lieu of the common day accommodation code, no payments in amounts in excess of contract requirements were made. At the Department's request, however, CSC has now implemented two SDNs to prevent possible overpayments when billing for codes 3160 and 3170 without code 3998.

CHAPTER III

MULTIPLE BILLINGS FOR THE SAME SERVICE

OVERVIEW

The Department has established policy to ensure that multiple payments for the same service are not made. Pursuant to this policy, the MMIS is designed to deny claims for previously paid services. We reviewed prepayment processing of three types of claims submissions which were identified as potential problem areas. These areas are radiology and pathology split billing, global obstetrical billings, and group versus rendering provider billings. We found that some overpayments were made for radiology and pathology services, that prepayment edit logic should be reviewed for obstetrical physician billings, and that the potential exists for overpayments to physicians who are also members of group practices. Incidentally, we found evidence that a potential for duplicate payments may exist.

RADIOLOGY AND PATHOLOGY SPLIT BILLING

In California, physicians providing radiology and pathology services in inpatient hospitals and long term care facilities can bill separately for the professional component of these services. The Department has developed policies to ensure that this type of split billing does not result in payments to

both physicians and facilities for the same service. However, during the period of our review, CSC had not been instructed to implement edits to enforce these policies. As a result, significant payments for the same radiology and pathology services were made to some providers in FY 84-85.

Split Billing

The Department's policy allows physicians to bill separately for the professional component of radiology and pathology services delivered in inpatient hospitals and long term care facilities. DHS does, however, have the authority to enforce reasonable billing procedures necessary to ensure that separate professional and technical component billings do not exceed the total allowable payment for the complete service. Pursuant to this authority, the Department has instituted procedures which physicians and facilities are required to follow when billing for radiology and pathology services. Current procedures allow these providers to bill for these services in one of three ways:

- The physician and facility can "split bill," with the physician billing for the professional component and the facility billing for the technical component. Physicians billing for the professional component are required to add a "26" modifier to the procedure code. Facilities billing for the technical component are required

to add a "27" modifier to the procedure code. In order to do this, the physician and the facility must have a "split billing agreement" on file with DHS.

- The facility can "standard bill" for both the professional component and the technical component (staff and equipment) and reimburse the physician for the professional component. Facilities billing for both components use the regular five-digit procedure code without any modifiers. In order to do this, the facility must have a "standard billing agreement" on file with DHS.

- Finally, the physician can "full fee bill" for both the professional and technical component and subsequently reimburse the facility for the technical component. Physicians billing for both components use the regular five-digit procedure code without any modifiers. In order to do this, the physician must have a "full fee billing" agreement on file with Medi-Cal.

Prepayment Edits

As indicated in a March 1984 problem statement, DHS recognized that providers were billing for radiology/pathology services incorrectly. The

Department found that both the hospital and the physician could bill and be paid up to 100 percent of the allowable reimbursement for the particular service. Physicians with split billing agreements are required to identify themselves by using Modifer 26 when billing for radiology or pathology services. Similarly, the institutional provider should bill using Modifier 27. When this is done, the system would pay each provider their portion of the total reimbursable amount. However, prior to the implementation of a new system edit, if the modifiers were omitted, the system would pay both the physician and hospital 100 percent of the reimbursable amount for that service.

Because the (then) existing prepayment edits could not verify all split billing situations, significant overpayments to providers of pathology and radiology services were made. A recent study conducted by FIMD identified approximately 70 hospitals which were receiving full payment for radiology services for which physicians were also billing separately for the professional component. FIMD estimated overpayments associated with this problem at $2.4 million per year.

From our review of 374 claims, we identified 31 claims (8.5 percent of sample) for radiology/pathology services where overpayments were made to physicians who billed for the professional portion of claims when a facility had billed for both the technical and professional portions. In one additional case, both the facility and physician were paid in full, because both billed

without the use of any modifiers indicating payment for technical and professional portions. The overpayments for the 32 claims reviewed amounted to $337.

For FY 84-85, we estimate with a 97.5 percent confidence level that over 150,000 radiology/pathology claims were paid in error. We estimate that, as a result, at least $1.3 million was overpaid in FY 84-85.

Conclusion and Recommendation

DHS officials informed us that in October 1985, CSC implemented a systems design change in the split billing edits that will resolve this problem. The systems design change requires providers to use Modifier 24 when billing for both the technical and professional components of radiology and pathology services. A claim failing to have a modifier for radiology or pathology will be returned to the provider for correction.

Further, DHS officials stated that overpayments made to both physicians and facilities would be recovered. These officials indicated that, in fact, postpayment reviews were now in progress to identify and recoup these overpayments.

We recommend that DHS follow through with the recovery of the FY 84-85 overpayments. In addition, we recommend that FIMD closely monitor

the effectiveness of the recently implemented system edit. The monitoring should determine whether the prepayment edit is effective in preventing overpayments and whether providers can circumvent the new edit.

GLOBAL AND SEPARATE OBSTETRICAL BILLINGS

Physicians who provide obstetrical care have the choice of billing globally (one fee for all maternity care services, including delivery) or separately for each service. However, a single physician cannot bill both ways for the same service. In our review, we found that one physician may bill globally, while a second physician may bill separately for the same obstetrical services. Presently, there are no prepayment edits that prevent billing by different providers for the same delivery, nor are there prepayment edits to prevent billing for the same service on different service dates. As a result, physicians may be paid more than once for the same services.

OB Billing Policy

According to the Department's Medi-Cal Policy Manual, a physician may bill globally (total obstetrical care) or on a per-visit basis. The physician also has the option of billing for the delivery only, for antepartum (prenatal services) only, or for postpartum (postnatal care) only. Further, if more than one physician is involved with providing obstetrical care, each is entitled to

bill separately for those specific services provided. However, one provider cannot bill for services globally while a second provider bills separately for services included in that global OB care service.

Global OB Billing Analysis

From our review of 358 recipient CDRs, we found only two billing situations which were inconsistent with policy. We found one case where an individual physician billed for the global OB care services provided to the same recipient on two consecutive days of service. In a second case, an individual physician billed and was paid for antepartum care and global OB care for the same recipient. For each of the cases, we evaluated how the claims were processed and paid.

In the first case, the first global OB claim was suspended for Error Code 831 ("Global Maternity Procedures and Office Visits not Allowed When Billed by the Same Provider"). However, the error code was overridden by CSC and paid. The second global OB claim also suspended for Error Code 831 and was overridden. For both of these claims, while suspending them was appropriate, the explanation for suspending them does not appear to be, since the error was billing the two global OB care claims and not that office visits were also billed. Only one global OB care should have been paid. The overpayment amount is $401.

In the second case, the antepartum care claim was paid without any suspense processing. The global OB care claim was suspended for Error Code 830, overridden, then paid for the total allowable amount. The amount was not adjusted for the $50 already paid for antepartum care. In each case, the error resulted from CSC inappropriately overriding error codes.

Because the error rate (less than 1 percent) relative to the sample size is so small, it is not statistically valid (using an acceptable level of probability) to project error rate to the universe of claims paid in FY 84-85.

Conclusion and Recommendation

The MMIS is designed with a prepayment edit to ensure that the same obstetrical service is not billed by the same provider on the same date of service. There is also an edit to ensure that global OB cannot be billed for the same recipient more than once in eight months. An additional edit restricts billing for global OB and office visits (antepartum and postpartum care) for the same recipient by the same provider. However, there are no edits to ensure that more than one provider is not paid for the same separate OB service provided to the same recipient.

We did not identify a pattern of improper billing and payment. Given that our review did not identify an extensive problem, the existing prepayment edits appear to be adequate to enforce Medi-Cal policy.

For the two cases described in the preceding section, the prepayment edits appear sufficient to prevent payment of claims without a review for consistency with policy. However, the edits appear to have been improperly overridden and the claims improperly paid. We recommend that DHS review CSC's edit logic and the suspense resolution procedures to ensure that Medi-Cal policy is being properly enforced.

Prepayment edits to prevent more than one provider from being reimbursed for the same service are more difficult to address. If a recipient obtains service from multiple providers, each has a legitimate claim for reimbursement. This situation must, therefore, be addressed as a part of the postpayment utilization review process. The DHS Surveillance and Utilization Review unit performs this type of analysis on an ongoing basis.

GROUP VERSUS RENDERING PROVIDER BILLING

Medi-Cal's policy allows rendering physicians who work for a group to bill for services under both group and individual provider numbers. Self-employed physicians bill for services rendered under a unique individual provider number. However, services rendered on behalf of a particular group provider by an individual physician working for a clinic, hospital, or other group provider may be billed under the provider number assigned to that group.

Currently, the system does not cross-reference edit against billing by providers associated with multiple provider numbers because providers do not always send information to DHS on group associations and changes in group associations nor is the information always sent in a timely manner. Further, edits and audits for duplicate/historical payments on all claim types are applied against the billing provider but not against the rendering provider. A possible result is that the services rendered by an individual provider could be paid to both the group practice and the individual physician.

Currently, the rendering provider is required on the professional services claim form when the billing provider number is a group number or when the rendering provider is an individual provider and is not the same as the billing provider. In cases where independent laboratories bill services on a professional services claim form, the rendering provider is usually the same as the billing provider and therefore usually is not listed under the rendering provider portion of the claim. The objective of our review was to determine whether duplicate payments are made if a provider bills for the same services under a group number and his own individual number.

To determine if the same provider billed under different provider numbers for the same service, 384 CDRs of professional services claims were reviewed. The recipient's profile was reviewed to determine if an identical

service was billed by the same provider for the same beneficiary on the same date of service.

The review identified no instances where services were billed by a provider under his individual provider number and as the rendering provider under a group provider number. Additionally, we did not find any instances where services were billed by the same rendering provider under two different group provider numbers.

A study conducted by the Department's Audits and Investigations Division (A&I) did identify overpayments involving this issue costing the State an estimated $500,000-1,500,000 per year. Therefore, while the potential remains for overpayments to be made to physicians who bill as both billing and rendering provider for the same service on separate claims, we did not find any evidence to support that current prepayment edits were inadequate. We recommend that DHS continue to monitor this potential problem area. If billing practices change so that it becomes a problem, DHS should then consider requiring redesign of prepayment edits.

DUPLICATE CLAIMS

Coincidentally with our audit tests, we identified two areas in which duplicate claims appear to have been paid. We further examined these potential duplicates.

Physician Claims

During our review of group versus rendering providers, we found eight cases where, from review of the CDRs, the claims appeared to be exact duplicates. All potential duplicates identified through our CDR review involved an exact match of billing provider number, recipient ID, procedure code, date of service, and paid amount.

However, further review of MR-O-154 reports and hardcopy claims showed that all eight claims had correctly suspended for duplicate payment review.

The eight suspended claims were overridden and paid. For all but one of these suspended claims, the override action by CSC was appropriate. We could not determine justification for the override for one claim based on information available to us.

Psychiatric Service Claims

Of the 383 recipient profiles reviewed for psychiatric service limits, seven contained payments for apparent duplicate services billed by the same

provider. We reviewed 12 sets of hardcopy claims and MR-O-154 reports for two of the six recipients. The claims appear to be exact duplicates; however, all claims were approved and paid without being suspended for duplicate payment review (Error Code 802). It is unclear why these claims were not suspended for review.

The total amount paid to this provider for the apparent duplicate services (for all six recipients) is $1,704.56. The CDRs for all recipients, in addition to the hardcopy claims and MR-O-154 reports for the 12 cases reviewed, were provided to FIMD for investigation.

Conclusion and Recommendation

Our analysis of the physician claims that appeared to be duplicates indicated that prepayment edits in the system were correctly identifying duplicate payments. However, we recommend that DHS review the circumstances of the one claim for which the edits appear to have been improperly overridden. If the override was, in fact, not justified, we further recommend that DHS review suspense procedures to ensure that proper justification exists for overriding edits.

All apparent duplicate psychiatric claims were submitted by the same provider. Although the system is designed to edit duplicate claims, these

claims did not suspend for review and were paid. We recommend that DHS review the prepayment edit logic to determine if a flaw exists which would allow these potential duplicates to be paid without suspense. We further recommend that this provider be reviewed by the DHS Surveillance and Utilization Unit as a potential abusive provider.

CHAPTER IV

BILLINGS IN EXCESS OF SERVICE GUIDELINES

OVERVIEW

The Department sets policy which sets guidelines on the frequency and duration of services. Specifically, there are limits on psychiatric services provided by a single provider in inpatient hospitals and long term care facilities. Additionally, there are rules for the use of time units and modifiers when billing for anesthesia services. We reviewed two types of billings identified as potential problem areas: psychiatric visits and anesthesia services. We found psychiatric services provided in hospitals and long term care facilities which exceeded guidelines and where the physicians rendering these services were paid. We found very few claims in our sample where it appeared that excessive anesthesia time units had been billed. However, since no formal anesthesia guidelines exist for anesthesia and thus there are no system edits, physicians can be paid for excessive anesthesia services. However, DHS officials indicated that extreme cases would be identified in postpayment reviews.

PSYCHIATRIC VISITS IN INSTITUTIONS

The Department's Medi-Cal Policy Manual sets guidelines on the frequency and duration of psychiatric services provided in hospitals and

Skilled and Intermediate Care Nursing Facilities (SNF/ICF). However, we found that physicians rendering psychiatric services are being reimbursed for claims which exceed these visit guidelines. DHS officials indicated that frequently used block billing practices make edits difficult to program. Hence, reimbursement of psychiatric services provided in inpatient hospitals or long term care facilities has not been completely controlled. As a result, some physicians rendering psychiatric services have been paid for services which exceed frequency guidelines.

Visit Frequency Guidelines

In conjunction with physicians who are in psychiatric practice, DHS has developed guidelines, or screens, for the frequency and duration of psychiatric visits to Medi-Cal beneficiaries in institutions. Specifically, psychiatric services in an inpatient hospital should not normally exceed seven hours for the first two weeks of care and, for each subsequent week, three-and-one-half hours per week. Psychiatric care provided in Skilled and Intermediate Care Facilities should not normally exceed a total of two hours of visits per week during the first two months after admission into the facility. Further, these guidelines indicate that a total of one hour per week during the third month through the seventh month from the date of admission, a total of one hour every two weeks after the seventh month, and a total of one hour per week during the month preceding release are payable. Claims exceeding these levels are to be manually reviewed prior to payment.

DHS officials indicated that these screens do not constitute Medi-Cal policy. These guidelines on frequency and duration of institutional psychiatric visits were developed by professionals in the field. Medi-Cal is currently using these guidelines to determine if policy should be established.

Visit Frequency Patterns

From our review, we found that physicians rendering psychiatric services are reimbursed for claims which exceed the inpatient and SNF/ICF visit screens. Of the 383 claims reviewed, we found that 17 claims for psychiatric services provided in inpatient hospitals and 14 claims for psychiatric services provided in LTCFs exceeded the screens. Claim payments in excess of the screens for our sample totaled $891.84.

For FY 84-85, we estimate with a 97.5 percent confidence level that at least 7,860 psychiatric service claims exceeded service screens for a single provider. We estimate that the payments for these psychiatric service claims are at least $212,506. However, these payments do not violate current Medi-Cal policy.

Conclusion and Recommendation

DHS had requested that CSC implement prepayment edits for the psychiatric service frequency screens. In responding to the SDN, CSC staff

stated that current "block" billing practices make enforcement of psychiatric limitations impossible. Block billing allows the physician to bill for frequent services provided on non-consecutive dates by reporting a block of time on the claim. For example, treatment may require a two-hour visit twice a week for three weeks. The physician will submit a bill for the three-week period without indicating actual dates of service. This type of billing practice precludes counting the number of treatment hours provided during a specified period of time. As a result, DHS did not pursue implementation of prepayment edits for these screens.

We found two claims in our sample where one physician "block" billed for non-consecutive dates of service. All of the other psychiatric service claims in our sample were billed on separate claim lines.

We recommend that DHS review the results of this review with psychiatric practitioners to determine if the current screens are appropriate. If those screens are appropriate, we recommend that DHS consider establishing these visit limitations as Medi-Cal policy. We further recommend continuing to implement prepayment edits for these service frequency screens.

DHS officials have stated that a policy to eliminate the block billing practice was being developed and that they plan to implement prepayment edits to enforce that policy.

ANESTHESIA SERVICE LIMITS

In billing for anesthesia services, physicians use unit values to indicate the time involved in delivering the service. Currently, the system accepts claims with a high number of time units because policy guidelines in this area have not been developed, and, therefore, prepayment edits for excessive time limits have not been required. As a result, physicians could be paid for quantities of anesthesia service which exceed generally acceptable units of service.

Anesthesia Guidelines

The Department has set guidelines to establish allowable units of time for anesthesia services:

- Anesthesia time begins when the anesthesiologist physically starts to prepare the patient for the induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist is no longer in constant attendance (when the patient may be safely placed under post-operative supervision). (The actual times of beginning and duration of anesthesia are required to be documented on the claim form.)

- The anesthesiologist must remain in constant attendance for the sole purpose of rendering anesthesia service.

- For non-obstetrical anesthesia, the time component is generally reported in 15-minute increments of anesthesia time for the first four hours and in ten-minute increments of anesthesia time thereafter. For obstetrical anesthesia, 15-minute time increments are applicable for the duration of the service. In each instance, five minutes or greater is considered a significant portion of time.

- Anesthesia time is billed by indicating the code numbers which identify increments of time. (There are separate codes for non-obstetrical anesthesia and obstetrical anesthesia.)

Anesthesia Billing Patterns

During our preliminary review, the State Controller's Office (SCO) and DHS staff indicated that there are occurrences of inappropriate or excessive billing of anesthesia quantities. In particular, SCO staff had indicated that over 100 units of service were billed for individual obstetrical procedures. On this basis, we reviewed a sample of 343 anesthesia claims.

We found that the system accurately prices claims based on the unit coding input from the claim and appropriately edits for manual pricing those claims coded 99 or 199 (over eight hours of anesthesia time). Also, if a claim has a quantity code other than a valid CSN code, such claims will also be suspended for manual review.

The CSN coding system uses quantity codes of "99" and "199" to indicate anesthesia services in excess of eight hours and a "100-199" range to indicate anesthesia quantity for obstetrical procedures, instead of coding the quantity to the actual number of anesthesia time units. Using this coding methodology, we found 50 cases (involving 19 of the 343 anesthesiologists sampled) where units of anesthesia provided in a single day exceeded ten hours. The table below summarizes the distribution of anesthesia cases exceeding ten hours provided by our sample of physicians. As shown, one provider billed for more than 50 percent of the total number of cases exceeding ten hours of anesthesia:

NUMBER OF CASES EXCEEDING TEN HOURS
OF ANESTHESIA BILLED IN A SINGLE DAY

Number of Hours	One Exceptional Provider	All Other Providers	Total
10-11	10	12	22
12-15	10	10	20
16-19	3	1	4
20+	4	-	4
Total	27	23	50

Conclusion and Recommendation

One purpose of this test was to determine if billing for excessive anesthesia services was extensive, and, thus, a prepayment system edit may be warranted. While based on our review more than 5 percent of the sampled anesthesiologists billed for more than ten hours of anesthesia in a single day, only 0.6 percent of those sampled billed for more than 16 hours for one day. Therefore, this problem does not appear to be as widespread as indicated to us in our preliminary review. Further, the test did not result in identification of an overpayment.

We do recommend, however, that DHS determine if policy can be established as to what constitutes excessive time units.

USE OF ANESTHESIA MODIFIERS

When billing for anesthesia services, physicians may use a two-digit modifier added to the surgical procedure code to further define the circumstances of the procedure. There is no established policy specifying inappropriate anesthesia modifiers for procedures, and, thus, there are no prepayment edits. However, we found providers using anesthesia modifiers inappropriately.

Background

Modifiers and time units are used in conjunction with service codes to bill for anesthesia services. For example:

- Modifier #38 is used to describe administration of anesthesia for emergency surgery on a patient with systemic disease.

- Modifier #32 is used to describe anesthesia procedures complicated by prone or difficult lateral position, surgical field avoidance, or for medical necessity.

- Modifiers that indicate difficult/unusual anesthesia situations, e.g., 32, 38, etc., are allowed only when documented for surgical procedures with an anesthesia base unit of "3."

- Claims for procedure codes 62274-62279 (injection of anesthetic substances for diagnosis or therapeutic purposes) should be denied if billed with any anesthesia-related modifiers.

- For surgeries where the surgeon personally administers a regional (injection) anesthetic, the injection procedure should be included in the billing for the surgical anesthesia under the appropriate surgical procedure code with an anesthesia modifier.

The reimbursement for anesthesia services is then determined by the use of these modifiers and the time units associated with the length of anesthesia.

In June 1984 and under DHS instruction, CSC had issued a provider bulletin stating that anesthesia injection procedures may not be billed with anesthesia modifiers and are not reimbursable if billed for anesthesia services.

Use of Modifiers

In testing the use of modifiers that indicate difficult/unusual anesthesia situations, a sample of 40 claims billed by anesthesiologists for a selected group of four procedure codes with an anesthesia base of "3" with modifier 32 or 38 were evaluated.

In our review, we found that some physicians appeared to misuse modifier 32 (difficult positioning) in conjunction with surgeries that generally do not involve difficult positioning, i.e., cataracts and appendectomies. The system, however, will only allow payment of one unit of service for these procedures, even when modifier 32 is used. Therefore, the system correctly reduces the extra units of service.

To determine if claims for anesthesia injection procedures were being paid although anesthesia modifiers had been billed, a sample of 124 claims

billed by anesthesiologists for procedure codes 62278 and 62279 with anesthesia modifiers were reviewed.

In our four-month review, we found 95 claims for anesthesia injections totaling $14,902 that were paid even though the modifiers were used. Further, we estimated that, in FY 84-85, at least 268 such claims were paid, totaling at least $42,041. These payments occurred because DHS had not instructed CSC to update the procedure file, which would ensure denial of these claims.

Conclusion and Recommendation

Although some providers may misuse modifiers 32 and 38, the existing prepayment edits prevent overpayments for these claims.

We recommend that DHS develop a prepayment edit to prevent payment for specified anesthesia injections when billed with anesthesia modifiers.

DHS officials stated that FIMD has recently developed an OIL requesting CSC to change the procedure file to deny these procedures if billed with anesthesia modifiers. The Department plans to recoup payments for improperly billed anesthesia injections back to June 1984.

APPENDIX A

CLAIMS SELECTION CRITERIA

SELECTION CRITERIA

For each of the six audit areas (or subset thereof) to be analyzed, a set of claims selection criteria was developed. These criteria were used in a sampling/extract computer program to select individual claims for review.

The specific selection criteria used by the sampling program were:

- Contract hospital-included services:
  - For a sample of 56 contract hospitals, a random selection of claim type 03 (inpatient hospital) was computer generated.
  - Contract hospital profiles were evaluated to determine which procedures were covered under the hospitals' contracts and, hence, should not be billed separately.

- Recipient profiles (CDRs) were obtained for 382 claims to determine if outpatient services billed were covered under the hospitals' contracts.

• Contract hospital fee-for-service billing:

- For the same sample of contract hospitals, five different ranges of procedures were selected to determine if contract IDs were used to bill for these services covered under the hospitals' contrats.

- The computer generated all claims for these procedures where both the fee-for-service ID and contract ID were used for billing.

- The RF-O-34 output was reviewed to evaluate why both ID numbers would be used. CDRs were not required.

• OB common day:

- For the same sample of hospitals, facilities with OB accommodation codes covered under contract were selected.

- The computer selected a sample of claims with OB care procedures and OB accommodation codes.

- Recipient profiles (CDRs) were obtained for a random selection of 382 claims to determine if OB accommodations were appropriately billed.

- Radiology and pathology split billing:

  - A computer-generated sample of claim type 04 (outpatient services) with radiology and pathology procedures without modifiers was produced.

  - From this list, a random sample of 384 claims was selected for recipient profile (CDR) review.

  - For each sample claim, we looked for physician billings (claim type 05) for the same radiology and pathology procedures for the same recipient and same date of service.

- Global and separate obstetrical billing:

  - A computer-generated sample of claim type 05 (professional services) with global OB care procedure codes was produced.

  - From this list, a random sample of 384 claims was selected for recipient profile (CDR) review.

  - For each sample claim, we looked for separately billed global and other OB care services provided by the same provider for the same pregnancy.

- Group and rendering provider billing:

  - A computer-generated sample of claim type 05 (professional services) billed by group providers was produced.

  - From this list, a random sample of 384 claims was selected for recipient profile (CDR) review.

  - For each sample claim, we looked for duplicate billings (for the same services provided on the

same day) billed by another provider number but rendered by the same provider.

- Psychiatric visits in institution:

  - A computer-generated sample of claim type 05 (professional services) billed by individual physicians for psychiatric service visits to inpatient hospitals and long term care facilities was produced.

  - From this list, a random sample of 383 claims was selected for recipient profile (CDR) review.

  - For each sample claim, we determined if psychiatric service limitations were exceeded by calculating the number of hours provided to that recipient by the same provider. Date of admission (for inpatient hospital recipients) and first date of psychiatric service (for long-term care facility recipients) were used to determine the allowable number of psychiatric visits for that recipient and provider.

- Anesthesia service limits:

  - A sample of anesthesiologists was selected for reviewing the number of hours per day that are billed to Medi-Cal.

  - A listing (dated 9/3/85) of all California providers with specialty code 05 (anesthesiology) was provided by DHS' Provider Relations Unit. A total of 4,961 anesthesiologists were listed.

  - Provider profiles (CDRs) of all providers sampled were requested from CSC to review billings on a daily basis for the review year (July 1, 1984 - June 30, 1985). Profiles were ordered by provider ID, date of service, and units of anesthesia.

- Anesthesia modifiers - difficult positioning:

  - All claim type 05 (professional services) with anesthesia modifier 32 (difficult positioning) and procedure codes for which "difficult positioning" would not generally be allowed (44950, 44955, 44960, 66820-66945) were computer-generated.

- From this list, we determined if payment amount was correct.

- Anesthesia modifiers - anesthesia injections:

  - All claim type 05 (professional services) for procedures 62274-62279, 64400, and 64530 where anesthesia modifiers were used were computer-generated.

  - From this list, after omitting all claims with dates of service prior to June 1, 1984, we totaled the number and amount of the claims paid.

SELECTION METHODOLOGY

After the claims selection criteria were developed, the following methodology was employed to select the individual claims for review:

1. For each audit area, a subsample of claims was selected from the total or random sample selected by the extraction program.

2. The desired size of the sample to be reviewed ranged from 381 to 384 per criterion. For any criteria for which the program extracted fewer than 381 claims, all claims were to be reviewed.

3. The subsample was selected on the basis of terminal digit sampling from the 11th digit of the claim control number. The terminal digits were selected from a table of random numbers. Different terminal digits were selected for each criterion.

4. If oversampling or undersampling occurred, the sample size was corrected by further terminal digit sampling on the 10th digit of the CCN.

5. In a few cases, where only a few additional claims were needed, selection was done through a random selection of 10th and 11th digits from a random table.

6. All selected claims were entered into a request program to produce claim detail reports for review.

7. Copies of relevant claim documents and MR-O-154 reports were requested for each claim reviewed.

APPENDIX B

SAMPLE SIZE DETERMINATION

METHODOLOGY

The following steps were followed to determine the sample size for each area:

1. Attribute sampling was used to estimate the rate of occurrence of an error. Variable sampling was used to estimate the dollar impact of the error where applicable.

2. To estimate the rate of occurrence, or frequency, of an error with attribute sampling requires the following information:

   - Desired confidence level
   - Desired precision
   - Estimated error rate in the population
   - Population size

3. The confidence level used was 95 percent. The desired precision was between 1 and 5 percent, depending on the frequency of the error in the sample.

4. Using the above method and sampling tables published by Arkin (Handbook of Sampling for Auditing and Accounting), we determined our sampling size for each test.

SAMPLE SIZES

The sample sizes used for each audit test are displayed in the table on the following page.

Audit Test	Universe Size	Extracted Sample	Sample Size Reviewed	
			Selected	Actual
Contract Hospital OB Common Day Billing	7,959	1,138	382	339
Contract Hospital Services Billed Separately	10	10	10	10
Contract Hospital Admissions With Outpatient Services	21,988	1,101	382	367
Group Versus Rendering Provider Billing	1,864,593	931	384	384
Global Versus Separate OB Care Billing	17,843	1,784	384	358
Radiology/Pathology Split Billing	1,107,156	1,383	384	374
Psychiatric Service Billing	51,608	1,148	383	383
Anesthesia Services with Difficult Positioning Modifier	40	40	40	40
Anesthesia Services With Modifiers	124	124	124	124
Excessive Anesthesia Billing	4,961	4,961	381	343

APPENDIX C

ESTIMATION METHODOLOGY

Two statistical estimation methodologies were used to determine the materiality of issues presented in this report. To determine the estimated rate of occurrence of an issue, we used the Attributes Estimation method. To determine potential dollar impact, we used the Variables Estimation method.

For both methods, we calculated the amount of sampling error at the 95 percent confidence level. At this level, our sampling precision (t) was $\pm$ 1.96.

To keep the estimate conservative, the lower limit of the confidence interval was used in both methods. In using this one-tailed test, the confidence interval of the lower limit increased from the 95 percent confidence level to the 97.5 percent confidence interval.

ESTIMATED RATE OF OCCURRENCE

Under the Attribute Estimation method, the estimated rate of occurrence of an attribute (condition) in a universe is the rate of occurrence in the sample. Therefore, our estimated rate of occurrence was calculated as:

$$p = \frac{\text{Number of observations of an attribute}}{\text{Sample size}}$$

The degree of sampling error for an attributes estimation is the Standard Error of the Percentage (SEP):

$$SEP = \pm \; t\sqrt{\frac{p\ (1 - p)}{n}}, \text{ where:}$$

SEP = Standard Error of the Percentage
t = Sampling precision (1.96)
p = Estimated rate of occurrence
n = Number of sampling units in the sample

The confidence interval of the estimate of the rate of occurrence of an attribute (expressed as a percent) is, therefore:

$$p \times 100 \pm SEP \times 100$$

ESTIMATED DOLLAR IMPACT

The potential dollar impact of an issue was estimated using the Variables Estimation Method. The total dollars determined to be an overpayment were divided by the sample size to calculate the average overpayment per sampling unit. The formula is:

$$\bar{x} = \frac{\sum x}{n}$$, where:

$\bar{x}$ = average amount of overpayment per sampling unit

x = amount of overpayment in each sampling unit, including $0 overpayments

n = number of sampling units in the sample

The average overpayment per sampling unit in the sample is the estimated average overpayment of each unit in the universe.

The sampling error of the estimate of the dollar impact is the Standard Error of the Mean. To calculate the Standard Error of the Mean (SEM), the standard deviation (or dispersion around the mean) of the overpayments must be calculated. The formula for the Standard Deviation is:

$$SD = \sqrt{\frac{\sum (x - \bar{x})^2}{n - 1}}$$, where

SD = Standard Deviation

x = amount of overpayment in each sampling unit, including $0 overpayments

$\bar{x}$ = average amount of overpayment per sampling unit

n = number of sampling units in the sample

The Standard Error of the Mean can then be calculated, based on the Standard Deviation:

$$SEM = \pm t\left(\frac{SD}{\sqrt{n}}\right), \text{ where:}$$

SEM = Standard Error of the Mean
t = Sampling Precision (1.96)
SD = Standard Deviation
n = Number of sampling units in the sample

The confidence interval of the estimated dollar impact per unit in the universe is, therefore:

$\bar{x} \pm$ SEM, expressed as dollars

UNIVERSE

The samples used were extracted from a randomly selected four months. The estimates calculated can be directly applied to the known population of units of the four months.

Because the units sampled are not counted and displayed on Medi-Cal reports as such, the universe for the fiscal year 1984-85 had to be estimated. Thus, for example, radiology/pathology claims billed by facilities without modifiers is the universe of claims from which the sample was selected for that issue. These claims are a subset of the universe of outpatient claims (claim type 04).

To determine the universe of units for the year, the proportion of basic units to the number of total units of a claim type in the sampled months were applied to the year. Thus:

$$\text{Proportion} = \frac{\text{Number of basic units in the 4 months}}{\text{No. of units of the related claim type in the 4 months}}$$

For the fiscal year:

$$\text{Estimated number of basic units} = \text{proportion} \times \text{no. of units of the related claim type for the year}$$

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

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Mr. Thomas W. Hayes
Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

James Stockdale has asked that I respond directly to your December 18th letter, and thank you for the opportunity to review a draft copy of your report, "Audit of the Medi-Cal Claims Processing System". I appreciate the efforts of your staff to ensure that the report is accurate, fair and helpful.

As you are aware, the Medi-Cal Claims Processing System is highly complex and very large, processing nearly $4 billion of claims a year. I was extremely pleased with the general finding of this report that there was "... no evidence of a high claims processing error rate." As with any complex program, there are always improvements that can be made.

The audit covered facits of the system which appeared to the auditors to have the most potential for improper Medi-Cal payments. In several cases it found that no problem existed or that the Department had taken steps to resolve the problem. The audit also looked at areas of payment which are reviewed by the Department on a postpayment basis and concurred with that approach. Finally, the audit found one payment problem (payment of anesthesia injections) which the Department was not aware of, but which we have now corrected.

In closing, I would like to say that when one considers the magnitude and complexity of the Medi-Cal program, the claims are processed remarkably well. I am pleased that the audit supports that contention.

The Department's detailed comments on the report are enclosed. Further, Computer Sciences Corporation has conducted an independent review of the draft report and their comments will be submitted under separate cover.

Once again, I would like to thank you for your efforts. Questions may be directed to Ben Thomas at (916) 322-7598.

Sincerely,

Kenneth W. Kizer, M.D., M.P.H.
Director

Enclosure

ATTACHMENT

DETAILED DHS COMMENTS
DRAFT AUDITOR GENERAL'S REPORT
"AUDIT OF THE MEDI-CAL CLAIMS PROCESSING SYSTEM"

CONTRACT HOSPITAL BILLING

Included Service Billing

Certain outpatient/physician services have been included in the per diem rate of hospitals by contract. If these services were provided by the hospital's outpatient department as part of the admission, these services should be billed on the inpatient claim form and reimbursed under the contract per diem rate. The Department currently reviews any improper billings by providers for these services on a postpayment basis and recoups any payments detected in error, as prepayment editing would be too costly and cumbersome. The audit report indicated that during the four month period reviewed, separately billed services totaled not more than $70,142. The report concluded that a prepayment edit would be extremely complex and costly to develop. Therefore, the recommendation was to identify and recoup these excess reimbursements through a postpayment review process.

We were very pleased to note that the incorrect billings found were very low as compared with total payments for inpatient hospitalizations and that the audit recommendation agreed with Departmental efforts.

Fee-For-Service Billing

Contract hospitals are required to bill certain services under their contract per diem rate and other services in the traditional manner. The audit found that all sampled claims were paid correctly.

Common Day Billing

Most contract hospitals may only bill for one accommodation (room and board) charge per day, to include the mother and child when both are post-delivery inpatients of the hospital. The review found that no payments were made in amounts in excess of contract requirements.

RADIOLOGY/PATHOLOGY

Radiology and pathology services are generally divided into technical and professional components which can be billed either as separate components or together by physicians, hospitals or laboratories. Who bills which components is defined by agreements between the parties involved. Medi-Cal policy allows this service to be billed separately (split billed) or together; however, only 100% of a service may be billed.

The audit estimates that at least $1.3 million was overpaid in FY 1984-85. In the past, the Department has utilized postpayment reviews, such as the one cited in the report, to control this area of billing. As cited in the audit, the Department is developing an approach to control these payments on a prepayment basis and is exploring recouping the overpayments identified.

GLOBAL AND SEPARATE OBSTETRICAL BILLINGS

Medi-Cal policy allows physicians who provide obstetrical care to bill globally (one fee for all maternity care services, including delivery) or separately for each service. The review looked at 358 recipients and only found two billing situations which were inconsistent with policy. Both of these situations were attributable to human error. The review concludes that it did not identify an extensive problem and that the existing prepayment edits appear to be adequate to enforce Medi-Cal policy.

The review recommends that we review Computer Science Corporation's (CSC's) logic and the suspense resolution procedures to ensure that Medi-Cal policy is being properly enforced, and we will follow that recommendation.

GROUP VERSUS RENDERING PROVIDER BILLING

Medi-Cal policy allows rendering physicians who work for a group to enroll as part of the group as well as individually. Providers must bill for services provided according to whether the group or the individual is legally responsible for the services. The review looked at 384 beneficiary histories to determine if providers were billing incorrectly (as both the group and individual). It identified no instances where services were billed by a provider under both his individual provider number and as the rendering provider under a group provider number. Additionally, there were no instances where services were billed by the same rendering provider under two different group provider numbers.

Duplicate Claims

Physician claims and psychiatric service claims were reviewed by the audit for duplicates. The report indicated that the prepayment edits in the system correctly identified duplicate payments for the physician claims; however, the audit raised concern regarding system processing for the psychiatric duplicate claims and recommends that the Department review this area. The Department is currently reviewing the system's processing of duplicate payments and will take corrective action, including recouping any overpayments.

PSYCHIATRIC VISITS IN INSTITUTIONS

Medi-Cal policy sets guidelines on the frequency and duration of psychiatric services provided in hospitals and skilled and intermediate care nursing facilities, which, if exceeded, require greater review before payment is made. The Department has been pursuing implementation of these guidelines in the claims processing system which has been delayed due to the complexity of system editing caused by block billing. As the Department is eliminating block billing, these edits will soon be in place. The audit found psychiatric services provided in hospitals and long term care facilities which would have exceeded the guidelines, had they been in place. The audit recommends that the Department continue to implement these prepayment edits.

ANESTHESIA SERVICE LIMITS

The audit attempts to determine if providers are billing for anesthesia services which involve an amount of time in excess of what is normally possible in a given day. The audit did not find a widespread problem or any overpayments. The audit did find one exceptional provider billing four times for over 20 hours of service in a given day.

A part of the Department's post payment audits and investigation review process is to detect providers who bill anesthesia outside of peer group norms. Through this process, we currently investigate providers who bill anesthesia beyond the norm. This includes providers who bill "excessive" anesthesia time. The provider cited in the report has been referred for further postpayment review.

Use of Anesthesia Modifiers

Physicians billing for anesthesia services may use a two digit modifier to further define the circumstances of the procedure. The audit found that even if a provider misused a modifier, an accurate payment was still made. However, the review found 95 claims for anesthesia injections paid incorrectly because the Department had not informed CSC to update the procedure file.

This audit finding identified a problem which had yet to be discovered. The audit prompted us to develop instructions requesting CSC to change the procedure file to deny this procedure if billed with anesthesia modifiers. The Department plans to recoup payments for improperly billed anesthesia injections as far back as June 1984.

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January 3, 1986
CSC Ref. #6561A

Mr. Thomas W. Hayes
Auditor General
Office of the Auditor General
State of California
660 J Street, Suite 300
Sacramento, CA 95814

Subject: Audit of the Medi-Cal Claims Processing System

Dear Mr. Hayes:

CSC has reviewed the draft audit report referenced above and herein provides our comments.

The audit report concludes that, "the number of erroneous payments was relatively very small." CSC concurs with this evaluation. We think it is worthwhile to emphasize further that the focus of the audit was a prepayment review. Payments in several of the test areas are intentionally adjusted (when necessary) in a post-payment mode. Had this component of the claims processing system been included in the audit, the number of "erroneous payments" would have been even lower.

Additionally, it should be noted that implementation of the two SDN's referenced in Paragraph 2 on Page 28 of the report has been completed.

Thank you for the opportunity to provide our comments in this matter.

Very truly yours,

Garth C. Treude
Vice President
California Operations

DC:jlm

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps